





Steven M. Thompson Physician Corps Loan Repayment Program

Loan Repayment Application

This project is supported in part by a grant from The California Endowment

Giving Golden Opportunities by:

Increasing the supply of health professionals practicing in underserved areas

Improving access to healthcare in rural and urban areas of California

Helping students to pursue a career in the health professions

Awarding health professionals who are dedicated to practicing in underserved communities

Application Instructions



The Health Professions Education Foundation (Foundation) recognizes the necessity of improving conditions which lead to healthcare disparities in the state, including those disparities arising from cultural and linguistic barriers. At the same time, the Foundation acknowledges the difficulty of many culturally or linguistically competent physicians to practice in underserved areas because of the heavy debt load that they carry from acquiring a medical education. The *Steven M. Thompson Physician Corps Loan Repayment Program* encourages physicians licensed to practice medicine for the first time in the United States or Canada within the past fifteen (15) years to practice in underserved locations in California by authorizing a plan for repayment of their educational loans in exchange for their service in a designated underserved area for a minimum of three years.

The *Steven M. Thompson Physician Corps Loan Repayment Program* repays up to \$105,000 in outstanding government or commercial educational loans for expenses incurred for undergraduate education and graduate medical education.

LOAN REPAYMENT AWARDS

The Foundation, under the *Steven M. Thompson Physician Corps Loan Repayment Program*, is authorized to repay outstanding government and commercial educational loans only, for expenses incurred during undergraduate and graduate medical education (i.e., principal, interest, and related expenses for tuition, educational expenses, and reasonable living cost). Award recipients are responsible for making continued loan payments during the course of their participation in this program, since the program only makes payments at the end of each service year.

A maximum of \$105,000 may be made available to program participants as an educational loan repayment. After completing the first year of service, the participant may receive up to \$25,000; after the second year, up to \$35,000; and, after the third year, up to \$45,000.

In no event shall the cumulative amount of the educational loan repayments exceed the amount of the participant's outstanding educational loan balances as of the date the written agreement is signed between the Foundation and the award recipient.

If the amount awarded is less than \$105,000, then 24 percent of the award will be granted at the end of the first year of service, 33 percent at the end of the second year of service, and 43 percent at the end of the third year of service.

Loan repayment recipients will be required to sign a written contract with the Foundation outlining the provisions which must be met to fulfill the obligations under this program.

LOAN REPAYMENT ELIGIBILITY

Loan repayment awards are available to Physicians who hold a full and unrestricted license to practice medicine in California. Osteopathic Physicians are not eligible for the program.

If you are not licensed to practice medicine in California when you apply to the loan repayment program, you must ensure that your Physician's and Surgeon's Application is submitted to the California Medical Board promptly. In order to be eligible for participation in the loan repayment program, you must be licensed in California before the final filing date. If you are not licensed by the final filing date, the application shall not be considered and shall be returned to the applicant.

Physicians awarded under this program must complete a 3 year service obligation to practice as a full-time physician in a medically underserved area of California providing direct patient care. Full-time means providing medical services for a minimum of 40 hours per week, for a minimum of 45 weeks per year. The 40 hours per week may be compressed into no less than 4 days per week, with no more than 12 hours of work in any 24-hour period. This does not include hours spent on call. At least 32 hours per week must be spent providing clinical services at the approved practice site(s) during normal office hours, except that, for physicians who are continuously engaged in the practice of obstetrics, at least 21 hours must be spent providing clinical services in addition to deliveries and other inpatient coverage. Absence from the practice cannot exceed 7 weeks in a calendar year except as otherwise required in order to comply with applicable federal and state laws.

SELECTION CRITERIA

The most qualified applicants will be selected in the areas of California with the greatest need: health care settings in medically underserved areas with at least 50 percent of the patients from a medically underserved population. Priority consideration will be given to the applicants best suited to meet the cultural and linguistic needs and demands of patients, based on the applicant meeting one or more of the following criteria:

- Speak a Medi-Cal threshold language: Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese (A County specific matrix is on the Website).
- Come from an economically disadvantaged background
- Have received significant training in cultural and linguistically appropriate service delivery
- Have three years of experience working in medically underserved areas or with medically underserved populations
- Have recently obtained a license to practice medicine in any state of the United States or in Canada.

Priority will be given to those applicants who have completed a three-year postgraduate residency in the areas of family practice, internal medicine, pediatrics, or obstetrics/gynecology; however, up to 20 percent of the available positions may be filled by applicants from other areas. Other criteria will be used in selecting those persons best suited for this program.



Application Instructions (cont.)



ELIGIBLE PRACTICE SETTINGS:

When submitting an application, the applicant may already be working at, or must have entered into a written agreement to provide services under this program with an appropriate practice setting. If an applicant is proposing a work arrangement with multiple practice settings, the applicant shall list those clinics on a separate page and identify the percentage of hours to be provided at each site.

If an applicant is interested in participating in this program but has not been able to "match" with a specific practice site, please check the Foundation's website. The Foundation will be listing those practice settings which are interested in recruiting physicians as well as "unmatched" applicants who are interested in participating in this program.

An appropriate practice setting as defined in California Health and Safety Code Section 128552(f) means, in part, either: (1) A community clinic, a clinic owned or operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to the California Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved area and at least 50 percent of whose patients are from a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

Medically Underserved Areas as defined in California Health and Safety Code Section 128552(d), in part, are areas as defined in the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist under the California Health and Safety Code.

Medically Underserved Population as defined in California Health and Safety Code Section 128552(e) are the Medi-Cal, Healthy Families, and uninsured populations.

Clinics must pay prevailing wages to program participants. Clinics must agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.).



SUBMIT THE FOLLOWING:

Personal Statements (Part D of the Application)
 Attach your personal statements to the application. Your statements must be typed. Statements must provide a comprehensive response to each question. Please limit all Personal Statements to not more than 2 pages. Restate and number each question along with your answer.

2. Certification of Practice Setting

This form must be signed by an official in your personnel or human resources department.

3. Educational Debt Reporting Form

Submit the attached educational debt reporting form and copies of your most recent lender statements with your name, the name of lender, balance owing, account number, and monthly payments. All information must be filled in or the application will be considered incomplete.

APPLICATION SUBMISSION

Applications must be postmarked by the deadline. In order to be reviewed, each part of the application must be completed. All supporting documentation must be submitted. The Foundation will notify applicants if their application is received incomplete. Do not bind or submit applications in a loose-leaf binder.

Submittal of an application and a written agreement with an acceptable practice setting does <u>NOT</u> ensure that applicants will receive a loan repayment. The Foundation anticipates that many physicians will apply, but only a limited number of positions can be funded.

NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results within 120 days of the final filing date.

APPLICATION POSTMARK DEADLINE: MARCH 24, 2007

Submit applications to:

Health Professions Education Foundation Steven M. Thompson Physician Corps Loan Repayment Program 818 K Street, Suite 210 Sacramento, CA 95814

(800) 773-1669 or (916) 324-6500

$Application \ \ {\it Please refer to the application instructions before you begin.}$

Do you owe an existing service obligation to another entity? Yes No If yes, please explain? (Previous obligations must be completed before applying):

Yes (Continue with Question 7a) No (Continue to Question 8)

Please enter the	loan repayment	amount
you are requestin	ıg:	



Please refer to the application instructions when completing the application documents are submitted with your application. Applications must be postm	
PART A – PERSONAL INFORMATION Applicants may apply for only one award using this application. (Please type or print your answers legibly in the space provided.)	7a. How many years of experience do you have working in a medically related field locate in a medically underserved area or serving a medically underserved population? Years:
Applicant's Name:	8. Have you successfully completed an ACGME (US) or RCPSC (Canada) postgradua
Mailing Address:	training program, and for how many years were you in this program? (If you answ yes to any specialty training in Question 8, please continue with Question 8c)
City: State: Zip:	Yes: Family Practice Years: Yes: Internal Medicine Years:
County:	☐ Yes: Pediatrics Years:
Permanent Address:	Years:
City: State: Zip:	Yes: Other Specialty Years:
County:	☐ No: I am currently in training (Continue with Question 8a)
Home Phone: Work Phone:	8a. If you are still currently in training, in what specialty?
Email:	8b. When will you complete your last year of training? Date:
Social Security # Date of Birth://	8c. Please list each accredited postgraduate training program in which you have
CA Drivers Licence #	participated.
PART B – QUALIFICATIONS & ELIGIBILITY	Dates of Attendance: From: To:
1. Do you hold a full and unrestricted license to practice medicine	Facility Name: State:
in California?	
If yes, provide license #	Dates of Attendance: From: To: To:
Date of initial issuance of this license:	City: State:
2. Are you licensed to practice medicine in any other jurisdiction in the United States or Canada?	Dates of Attendance: From: To:
	Facility Name: State:
In which jurisdiction: Date of initial issuance of this license:	
Date of fillinal issuance of this needse.	8d. Have you completed a fellowship?
3. Do you speak a Medi-Cal threshold language(s)? ☐ Yes ☐ No	If yes, in the specialty area of:
Which language(s)?:	Facility Name:Street Address:
	City: State: ZIP Code:
4. From which medical school did you graduate and what was the language of instruction?	Dates of Attendence: From: To:
	9. Have you had any medical training or experience in a country other than the
Medical School:Language of Instruction:	United States?
Language of Instruction:	10. Are you certified by a member board of the American Board of Medical Specialties
5. Did you complete a medical exchange program during medical school or postgraduate	Yes By the Board of:
training in which you provided services to a population that speaks a Medi-Cal	Date first certified:
threshold language?	■No
If yes, where did you serve?	11. Are you the first in your family to attend college?
If yes, where did you serve?	
	*MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS Disclosure of your U.S. Social Security Number is mandatory. Section 30 of the Business and
6. Have you received significant training in cultural and linguistically appropriate	Professions Code and Public Law 94-455 (42USCA 405(c)(2)(C)) authorize collection of your social
service delivery?	security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520
7. Do you have three years of experience working in any field (whether medically related or not) in medically underserved areas or with medically underserved populations?	of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application will not be processed AND you will be

Last Revised: 1/17/2007

reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

Application

App Inquiry:

Reviewed By:

Input By:



12. Do you come from an economically disadvantaged background?	1. How would your socioeconomic background benefit you in service under this
If yes, list the city, county, state, or country you grew up in. Check socioeconomic status and	program and would it benefit the patient population?
geographic characteristics for each applicable age category.	2. Why do you want to participate in the Steven M. Thompson Physician Corps Loan Repayment Program?
Age Category Rural Inner City/Urban Suburban Poor Middle-class Upperclass	
Birth-10 years County: State:	PART E – QUESTIONNAIRE
Country:	Where did you hear about the Steven M. Thompson Physician Corps Loan Repayment Program? (Check all that apply)
Age Category Rural Inner City/Urban Suburban Poor Middle-class Upperclass	Work (employer or co-worker) ☐ Friend/Acquaintance ☐ TV
11-20 years	Foundation Web site Other Web site Advertisement
City: State:	□ Newspaper or publication (please specify)
Country:	Organization or Affiliation (please specify)
Age Category Rural Inner City/Urban Suburban Poor Middle-class Upperclass 21-30 years	Other source (please specify)
City: State:	
Country:	Where did you receive the Steven M. Thompson Physician Corps Loan Repayment Program application form? (Check only one.)
Age Category Rural Inner City/Urban Suburban Poor Middle-class Upperclass 31-40 years	☐ Program Director/Instructor ☐ Foundation office
31-40 years	☐ Foundation Web site ☐ Other Web site ☐ Work (employer/co-worker)
Country:	☐ Friend/Acquaintance ☐ Other (please specify)
Age Category Rural Inner City/Urban Suburban Poor Middle-class Upperclass	PART F – APPLICATION CERTIFICATION
41+ years	I certify that I am the person herein named subscribing to this application; that I have
City: County: State: State:	read the complete application, know the full content thereof, and declare under penalty
	of perjury, that all of the information contained herein and evidence or other credentials
PART C – PROVISION OF SERVICES	submitted herewith are true and correct and that I am willing to sign, or have signed a written agreement with a practice setting committing to a minimum three years of
1. Are you willing to sign a written agreement with the Foundation, whereby you commit	full-time practice in a medically underserved area. I authorize the Health Professions
to a minimum of three years of full-time service in a Medically Underserved Area?	Education Foundation to verify any information submitted as part of this application. I
☐Yes ☐No	understand that falsification of information contained in this application will disqualify
2. Please list the practice setting at which you are working or have entered into a written agreement to provide services under this program during the next three years. If you	my application.
are proposing a work arrangement with multiple practice settings, please list these	I understand that once submitted my application and supporting documents become
clinics on a separate sheet and identify the percentage of hours to be provided at each	the rights of the Health Professions Education Foundation. I also understand that my personal statements become the property of the Foundation and may be used,
site. Further, each practice setting's Administrative Office must sign a certification;	including but not limited to, advertising/marketing, program reports, newsletters, and
submit an additional copy of this page for each additional practice setting, so the respective Administrative Officer can sign the certification below.	other publications.
(IMPORTANT: Please list the actual street address of the practice setting where you will be	BUIN 6
working, as this address is the primary factor in determining eligibility. Do <u>NOT</u> list the address of the clinic's administrative office.)	Print Name: (last name, first name, middle initial)
	Applicants Cignature.
Name of Practice Setting:Street Address:	Applicant's Signature: Date:
City:	SUBMISSION CHECKLIST
State:	
ZIP Code:	☐ 1. Personal Statements
Telephone Number:	2. Certification of Practice Settings
PART D – PERSONAL STATEMENTS	3. Educational Debt Reporting Form and Lender Statements
Attach your personal statements to the application. Your statements must be typed.	4. If applicable, written explanation of defaults or judgment liens
Restate and number each question along with your answer.	for any debt.
FOR OFFICIA	LUSE ONLY
Pacel: Compl / Inc:	Omitted: Ann Pas EDP Per State LoP Other

HPEF Contact:

Comments:

CT#:

Elig Prac Set: Yes / No

for:

Educational Debt Reporting Form

- List source and amounts of outstanding educational loans used to finance your education below.
- You must submit evidence of the educational debts listed below (i.e. current statements for referenced accounts which includes the current balance, account number, your name, and address to which payment is submitted.).



All spaces must be completed. If payments are **deferred** an amount must be entered into the monthly payment space.

If any information is missing the application will be considered incomplete.

LOAN 1		LOAN 4	
School Attended:		School Attended:	
Loan Period (Start Date): (End Date	e):	Loan Period (Start Date):	(End Date):
Loan Program:		Loan Program:	
Loan ID#:		Loan ID#:	
Lending Institution:		Lending Institution:	
Lender's Address:		Lender's Address:	
City: State:	_ Zip:	City:	State: Zip:
Outstanding Balance: \$ Monthly Paymen	t: \$	Outstanding Balance: \$	Monthly Payment: \$
LOAN 2		LOAN 5	
School Attended:		School Attended:	
Loan Period (Start Date): (End Date	e):	Loan Period (Start Date):	(End Date):
Loan Program:		Loan Program:	
Loan ID#:		Loan ID#:	
Lending Institution:		Lending Institution:	
Lender's Address:		Lender's Address:	
City: State:	_ Zip:	City:	State: Zip:
Outstanding Balance: \$ Monthly Paymen	t: \$	Outstanding Balance: \$	Monthly Payment: \$
LOAN 3		LOAN 6	
School Attended:		School Attended:	
Loan Period (Start Date): (End Date	e):	Loan Period (Start Date):	(End Date):
Loan Program:		Loan Program:	
Loan ID#:		Loan ID#:	
Lending Institution:		Lending Institution:	
Lender's Address:		Lender's Address:	
City: State:	_ Zip:	City:	State: Zip:
Outstanding Balance: \$ Monthly Paymen	t: \$	Outstanding Balance: \$	Monthly Payment: \$

Certification of Practice Setting



ATTENTION! The completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable.

FORM TO BE COMPLETED BY AN OFFICIAL IN THE PERSONNEL OR HUMAN RESOURCES DEPARTMENT (The person signing this form may not be related to the applicant by blood, marriage, or adoption)

Applicant's Name:	
Practice Setting:	
Address:	
City:	State: Zip Code:
County:	
	ter of the facility named in Part C, Item 2, of the application and that I have greement with the person named on this application to provide services at
Through our selection process, I have didentified on this application.	etermined that the applicant can speak the Medi-Cal threshold language
	the applicant prevailing wages and that I agree not to use the Program's as a means to reduce the recipient's salary or offset those salaries (e.g.,).
	ion of a "practice setting" as defined in California Health and Safety Code be verified with the Health Professions Education Foundation.
declare under penalty of perjury that the	hese statements are true and correct.
Name: (Please Print)	Title:
Signature:	Date:
Phone Number:	Fax Number:
Fmail·	



818 K Street, Suite 210 Sacramento, CA 95814 www.healthprofessions.ca.gov (800) 773-1669

BOARD OF TRUSTEES

Gary Gitnick, M.D., Chairman Chief, Division of Digestive Diseases and Professor of Medicine, UCLA Los Angeles, CA

Diana Bonta, R.N., Dr.P.H. Vice President, Public Affairs, Kaiser Permanente Pasadena, CA

Brenda Jackson Drake, J.D. Director, Public Health Trust Irvine, CA

Richard Fantozzi, M.D. San Diego, CA

Tadao Fujiwara, M.D., Pharm. D. Los Angeles, CA

Robert E. Hertzka, M.D. Rancho Santa Fe, CA

Barbara Johnston, M.S.N. Executive Director, California Telemedicine & eHealth Center Sacramento, CA

Harold A. Lancer, M.D., F.A.A.D.Beverly Hills, CA

Marcella Wing Low Public Affairs Manager, The Gas Company Redondo Beach, CA

Linda Lucks Venice, CA

Anmol Singh Mahal, M.D. Fremont, CA

Deepak K. Rajpoot, M.D. Chief of Pediatric Nephrology, UCIMC Orange, CA

Barbara Yaroslavsky Los Angeles, CA

EX-OFFICIO MEMBERS

David M. Carlisle, M.D., Ph.D. Sacramento, CA

Jimmy H. Hara, M.D. Los Angeles, CA

FOUNDATION STAFF

Stephanie Clendenin Interim Manager

Karen Isenhower Program Director